Patient Information

Today's Date:________________

Patient Name:____ Date of Birth:________________

Address:____ S.S. #______________________

City:___________________________ State:__________________ Zip:___________ Gender: M F

Home Phone:___________________ Work Phone:_________________ Cell Phone:___________________

Email address:______________________________________

Marital Status: (circle one) Married Single Widowed Hispanic or Latino? Yes No

Race: (check one): ☐ White ☐ African American ☐ American Indian
☐ Asian ☐ Alaska Native ☐ Native Hawaiian or Other Pacific Islander

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Insured Name (Policyholder):______________________________________ Date of Birth:________________

Address:____

City:___________________________ State:__________________ Zip:___________ Gender: M F

Home Phone:___________________ Cell Phone:_________________ Work Phone:___________________

Relationship of patient to insured: Self Spouse Dependent Child

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Primary Care Doctor: ____ Phone:________________________

Preferred Pharmacy: ______________________________________ Phone:____________________________

Address:_________________________________ City:_________________ State:_____ Zip:______________

Name of Doctor who referred you:_______________________________ Phone:________________________

How did you hear about Dr. Davis? ____

Emergency Contact: _____________________ Relationship to Patient:________________ Phone:__________

I would like to give Dr. Davis and his staff permission to discuss my medical condition and account with:

Name:________________________________ Relationship to Patient:________________ Phone:__________

Thank you!

COTTONWOOD PODIATRY
MURRAY PARK MEDICAL
Dr. Nathan W. Davis
154 E Myrtle Ave, Suite 201
Murray, UT 84107

Brief Medical, Family and Social History

Patient Name:____________________________________ Height:______________ Weight:___________

Reason for visit:____________________________ Duration of problem:_________________________________

If injury, please give date of injury: _____________________ Place of Injury: Work, Other________________

Allergies: *(check all that apply)*

☐ None ☐ Adhesive Tape ☐ Iodine ☐ Dyes ☐ Latex
☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Aspirin ☐ Other _______________________
Metals: ☐ Nickel ☐ Titanium ☐ Cadmium Local Anesthetics: ☐ bupivacaine ☐ lidocaine ☐ epinephrine

Are you taking any medications at this time? ☐ Yes ☐ No If yes please list below.

Medication	Dose	Medication	Dose	Medication	Dose

Do **you** have or have a history of any of the following? Please indicate specific problem on adjacent line.

☐ Eye Problems:______________________________
☐ Rheumatic Fever
☐ Heart Problems:______________________________
☐ Circulation Problems: _________________________
☐ Varicose Veins
☐ Swelling in foot or ankle
☐ High Blood Pressure
☐ Tumors or Cancer:____________________________
☐ Arthritis: ___________________________________
☐ Tuberculosis
☐ Gout

☐ Asthma
☐ Lung Disease
☐ Numbness in foot or leg
☐ Diabetes:_____________________________
☐ Epilepsy
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Aids
☐ Mental Illness/Depression/Anxiety
☐ Other:__________________________________

Have you had any serious illness or previous operations: ☐ Yes ☐ No
Please list:
____

Have any family members had any of the above? ☐ Yes ☐ No *Please list condition(s) with relationship to Patient:*____

Personal/Social History: *(check all that apply)*
Use of: ☐ Tobacco *(frequency)* _____________ ☐ Alcohol ☐ Recreational Drugs

Signature of patient or guardian:____ Date:________________